


Lessons Learned from the SEATS II Project

A faded, blue-tinted photograph of a woman in a field, seen from behind, carrying a long wooden handle (likely a hoe) across her shoulders. She is wearing a headscarf and a patterned wrap. The background is a field of tall grass or reeds.

# Enhancing the Sustainability Of Reproductive Health Services

John Snow, Inc.

March 2000

A stylized graphic of a globe in the bottom right corner, composed of horizontal blue and white stripes.

The goal of the Family Planning Service Expansion and Technical Support II (SEATS) Project is to expand the development of, access to, and use of high-quality, sustainable family planning and reproductive health services in currently underserved populations. SEATS is funded by the United States Agency for International Development (USAID) under contract number CCP-C-00-94-00004-10, and managed by John Snow, Inc.

John Snow, Inc. (JSI), an international public health management consulting firm, headed a group of organizations implementing the SEATS Project. These included the American College of Nurse-Midwives (ACNM), the American Manufacturers' Export Group, AVSC International, Initiatives, Inc., the Program for Appropriate Technology in Health (PATH), World Education, USAID Missions, and other partner organizations in each country where SEATS was active.

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This publication was made possible through support provided by the Office of Population, USAID, under the terms of Contract No. CCP-C-00-94-00004-10, and by JSI. The contents and opinions expressed herein are those of the author and do not necessarily reflect the views of USAID, JSI, or its partner agencies.



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## *Acronyms and Abbreviations*

ACNM	American College of Nurse-Midwives
AIDS	Acquired Immune Deficiency Syndrome
ANE	Asia/Near East
ANSFS	Association Nationale des Sage-Femmes du Sénégal
ASBEF	Association Sénégalaise pour le Bien-Etre Familial
CAFS	Centre for African Family Studies
CASP	Community Aid and Sponsorship Programme
CMA	Cambodian Midwives Association
CQI	Continuous Quality Improvement
EC	European Commission
ECSACON	East, Central, and Southern African College of Nursing
FP	Family Planning
FPIA	Family Planning International Assistance
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HAI	Health Alliance International
HDT	Health Development Team
HIV	Human Immunodeficiency Virus
ICM	International Confederation of Midwives
ICO	Independent Clinics Organization
IEC	Information, Education, and Communication
ICOMP	International Council on Management of Population
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
KfW	German Bank for Reconstruction
LDHMT	Lusaka District Health Management Team
MAPS	Midwifery Association Partnerships for Sustainability
MIS	Management Information System
MOH	Ministry of Health
NUEYS	National Union of Eritrean Youth and Students

NGO	Nongovernmental Organization
NHC	Neighborhood Health Committee
OIC	Opportunities Industrialization Centers International
PPAT	Planned Parenthood Association of Thailand
PVO	Private Voluntary Organizations
RH	Reproductive Health
RHAC	Reproductive Health Association of Cambodia
SANFAM	Santé de la Famille
SEATS	Family Planning Service Expansion and Technical Support Project
SSK	Sosyal Sigortalar Kurumu (Turkish Social Security Agency)
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TdH	Terre des Hommes
UNFPA	United Nations Population Fund
UPMA	Uganda Private Midwives Association
USAID	United States Agency for International Development
VSC	Voluntary Surgical Contraception
WAF	World AIDS Foundation
WRC	World Relief Corporation
YFS	Youth-friendly Services
ZINA	Zimbabwe Nurses Association
ZNA	Zambia Nurses Association
ZNFPCC	Zimbabwe National Family Planning Council

## Executive Summary

The enhancement of the sustainability of its in-country development partners and their activities has been critical to achieving the overall goal of The Family Planning Service Expansion and Technical Support II Project (SEATS)—to expand the development of, access to, and use of quality family planning (FP) and reproductive health (RH) services in currently underserved populations.

SEATS defines sustainability as the capacity of an implementing partner to provide quality reproductive health services at a steady or growing level to underserved populations while decreasing dependence on external aid. SEATS' collaboration with its partners has included assistance to: (1) strengthen their institutional and financial capacity; (2) increase the attractiveness of their program/services to their clients and potential investors (government, donors); and (3) expand their non-USAID funding from a combination of donor and local resources.

SEATS adopted a multidimensional approach to sustainability, one that was: *strategic*—integrated into subproject design; *fundamental*—addressing institutional and financial aspects; *client-centered*—focused on service delivery; *flexible*—suited to the level of an organization's development and operating environment; and *realistic*—balancing the mix of international and local resources.

**The key lessons learned from SEATS' experience in working with its more than two dozen implementing partners in 11 countries in Africa and Asia are:**

- ✦ *Invest in planning and management capacity.* Dedicated resources to increase and improve institutional—not just service delivery point—capacities to plan and manage development resources are fundamental to enhancing sustainability.
- ✦ *Manage the inherent tensions among rapid service expansion, service to the poor, and long-term sustainability.* A need to move rapidly in promoting the expansion of services is not always compatible with requirements to achieve long-term sustainability. There are trade-offs, and the poor are especially vulnerable to the consequences of this conflict.

- ✦ *Sustainability issues are effectively addressed through the continuous quality improvement (CQI) process of team-based problem solving.* The ability to respond effectively to a rapidly changing environment is a hallmark of organizational sustainability. This organizational capacity can be enhanced by the same data-driven team-based approach used for the continuous improvement of service quality.
- ✦ *Access to contraceptive commodities is critical for program continuation.* One of the critical parts of any FP/RH program is the steady supply of contraceptives; although fulfilling this need is often heavily donor dependent, it is often overlooked in sustainability planning efforts.
- ✦ *Public-sector and adolescent programs require special approaches to sustainability.* The limited policy, administrative, and financial autonomy of public-sector providers of reproductive health services requires sustained technical assistance to identify and develop untapped local resources that can enhance program sustainability. Adolescent reproductive health programs require approaches to address the special challenges of working in the particularly sensitive area of adolescent sexuality with clients having limited or no income.
- ✦ *Successful leveraging of additional resources can also create new organizational challenges.* Relationships with multiple donors can be complex. Often, funds from one donor will flow through several channels, making it difficult for the recipient to know whom to contact for different aspects of programmatic and administrative operations. Responding to donor requirements may distract the organization from focusing on its core mission activities.

**Some clear directions for enhancing sustainability are indicated by what has been learned through SEATS.**

First, and foremost, future efforts to enhance the sustainability of public and private providers of reproductive health services must ensure adequate time for capacity-building efforts. In practical terms, this means emphasizing low-cost expansion approaches such as outreach, when this is possible and realistic, over increasing fixed clinic sites and expensive technology, which adds recurrent management and financial costs that may significantly extend the time frame for realizing the organization's sustainability goals. It also suggests that programmatic flexibility, which allows support for initial recurrent and capital costs incurred in expanding services to underserved populations, should be weighed against an implementing partner's ability to absorb the costs in the future.

Second, the SEATS experience has shown that although there is no one approach that will work in all settings, there are sustainability activities that do work. The key is to plan activities around a clear understanding of the specific context within which a partner organization operates, and to consider the widest repercussions—both positive and negative—that result from the implementation of each activity. Developing services that are of value to the clients and the community should be a cornerstone of all sustainability efforts.

Third, the emphasis that continuous quality improvement of management and service delivery operations places on data-based, client-centered, team decision-making represents a basic organizational capacity to anticipate and respond effectively to an ever-changing operating environment. It can thus make a critical contribution to the long-term sustainability of the organization's operations.

Fourth, client populations must be appropriately segmented by their ability to pay for services. There are various approaches that can be used to improve the access of all segments to health education, and to needed services.



# *SEATS' Approach to Sustainability*

## **Background**

Project sustainability has become an important issue to program planners, managers, evaluators, and donors alike. Increasingly, projects are being evaluated based on their ability to diversify their funding base and to continue their programs after donor funding has ended. Sustainability, then, is part of sound project design, and is particularly important in today's funding climate.

The enhancement of the sustainability of its in-country development partners and their activities has been critical to achieving the overall goal of The Family Planning Service Expansion and Technical Support II Project (SEATS)—to expand the development of, access to, and use of quality family planning (FP) and reproductive health (RH) services in currently underserved populations and to ensure that unmet demand for these services is addressed through the provision of appropriate financial, technical, and human resources.

### **SEATS defines sustainability as:**

The capacity of an implementing partner to provide quality reproductive health services at a steady or growing level to underserved populations while decreasing dependence on external aid.

To this end, SEATS' collaboration with its partners has included assistance to:

- ✦ Strengthen their institutional and financial capacity;
- ✦ Increase the attractiveness of their program/services to their clients and potential investors (government, donors); and
- ✦ Expand their non-USAID funding from a combination of donor and local resources.

Since the start of SEATS operations in January 1995, a sustainability plan has been integral to each of the subproject designs developed with its implementing partners. These sustainability plans were developed through a four-step process. With SEATS technical assistance, each implementing partner:

**Figure 1. Sustainability Plan Elements**

- ✦ Internal Policy Commitment
- ✦ Quality of Care/Quality Improvement
- ✦ Financial Management/Cost Containment
- ✦ Functioning Cost Recovery System
- ✦ Coordination with Other Programs or Institutions and/or Revenue Generation
- ✦ Community Involvement
- ✦ Human Resources/Training Capabilities/Leadership
- ✦ Strategic and Financial Planning Capabilities
- ✦ Diversification of Services
- ✦ Marketing Capabilities
- ✦ Commodity Procurement/Management

1. Assessed the context within which the program would operate in order to identify potential barriers to its sustainability—USAID country objectives and policies; host government policies; the activities of other public and private providers of family planning/reproductive health services; economic conditions and their influence on service demand; and other donors’ policies and programs;
2. Identified existing institutional and financial elements that can help or hinder the sustainability of program services (see Figure 1 for a list of these elements);
3. Articulated sustainability objectives and the strategies for achieving them; and
4. Developed an integrated set of activities and management plan for implementing the sustainability plan (see Figure 2 for a list of key activities).

### Leveraging

SEATS never assumed that its support of its partners’ sustainability plans would lead to fully self-financed programs. Instead, the operating assumption has been that external support in some form would continue as part of the resource mix of its implementing partners. What varied was the scale of such support, its sources, and its terms. “Leveraging” was the name given to the process through which such support would be generated, whether locally or through external sources. It became a critical part of the project’s overall approach to sustainability.

**Figure 2. Sustainability Plan Activities**

- |   |                                  |
|---|----------------------------------|
| ✦ Local Fundraising                       | ✦ Quality Improvement            |
| ✦ Financial Management/Accounting Systems | ✦ Proposal Writing               |
| ✦ Budgeting                               | ✦ Identification of Donors       |
| ✦ Diversity Services & Method Mix         | ✦ Costs Analyses                 |
| ✦ Separate Revenue Generation             | ✦ Design/Revision of Fee Systems |
| ✦ Cost Management                         | ✦ Training Capacity              |
| ✦ Advocacy/Internal Support               | ✦ Management Information Systems |
| ✦ Marketing Services                      | ✦ Commodity Management           |
| ✦ Market Research                         | ✦ Strategic & Financial Planning |
| ✦ Basic Business Skills                   |                                  |
| ✦ Community Mobilization                  |                                  |

**SEATS defines leveraging as:** the ability of an organization to use its assets (facilities, skilled personnel, experience, programmatic expertise, successes) to attract the non-USAID support necessary to continue or expand its reproductive health services.

SEATS approaches leveraging as a marketing challenge. It requires thinking strategically about how to market an organization, its programs, its services, and its products so that there will be adequate financing for current and future plans.



Since its inception, SEATS sought opportunities to leverage support for expanding access to, and enhance the quality of, reproductive health services. Core project funds were leveraged to attract USAID field support and regional funding, allowing SEATS to expand its special programmatic initiatives. Also, building on the experience of SEATS I, SEATS leveraged in-kind contributions from its subprojects to cover those subprojects' recurrent costs. This allows SEATS funds to support targeted technical inputs while fostering the development of more enduring programs.

In January 1998, USAID authorized SEATS to expand its leveraging activities beyond traditional USAID sources of funding to include non-USAID sources. Although it came late in the project's life, this expansion of the SEATS sustainability mandate offered the project an opportunity for leveraging subproject investments to bring about continued support for reproductive health and family planning services. Consequently, SEATS' leveraging objectives exclude additional USAID funding, but allow for a range of other resources including non-USAID grants, fees from RH-related services, local donations, local government subventions, and international or local in-kind donations.

### Indicators of Success

While each subproject identifies appropriate indicators based on its specific sustainability plan, SEATS has a number of indicators it uses to monitor the extent to which it has achieved its objective. These include:

- ✦ Initial investment from the local partner including support of recurrent costs;
- ✦ Increased use of services;
- ✦ Improved planning, management, staff skills, leadership, and political support;
- ✦ Increased diversification of the funding base; and
- ✦ Increased income earned locally (including fees, local government stipends, local donations).

## A Multidimensional Approach to Sustainability

The nature of SEATS' support to its implementing partners sustainability reflects both their changing organizational needs as well as changes in the SEATS contract. Consequently, different institutional and financial elements that can help the sustainability of program services are selected for the sustainability plans of SEATS' various partners. This variation is presented in Table 2 on page 12. What has remained constant, however, is the project's approach to sustainability, which is strategic, focused on fundamentals, client-centered, flexible, and realistic.

### Strategic—Integrated into subproject design

To build its partners' capacity to sustain their family planning/reproductive health (FP/RH) program, SEATS incorporates sustainability into the design of the subproject. Most of its public-sector partners were required to cover the recurrent costs of their program activities, such as staff salaries and facility maintenance. Nongovernmental Organization (NGO) partners, many of whom are dependent on external funding for their reproductive health program, were also required to invest in program activities, including providing volunteer time and gradually covering a greater portion of their operating costs.

Such strategies have been readily acceptable when recipients could perceive personal benefits. For example, in Zimbabwe, the Bulawayo subproject understood from its beginning that it was expected to cover the recurrent costs associated with the Family Planning Training Center established with SEATS support. With assistance from municipal administrators, the City Health Department convinced the Bulawayo City Council to adopt the center and allocate additional funds to the City Health Department budget to cover its recurrent costs. Because Bulawayo accepted the need to cover costs from the start, it has been able to provide family planning training courses after SEATS support ended, training 28 participants in three separate courses during the quarter following the subproject end date.

### Fundamental—Addresses institutional and financial elements

SEATS also supported the enhancement of its partners' institutional capacities to attract and manage the resources needed to achieve their organizational goals. These capacities can be grouped into several broad management areas:

- ✦ **Strategic management**—Identifying, analyzing, and selecting the organization's mission and objectives, and developing and managing the implementation of plans to achieve those objectives;

- ✦ **Financial management**—Effectively operating practical accounting systems, systems for cost, revenue, and inventory management;
- ✦ **Client services management**—Assessing the need and demand for particular services, as well as the opportunities for recovering part or all of the costs for providing those services; providing those services in a manner and at a cost that enhances their use by the intended clients; and monitoring the external environment for changes that either threaten current service delivery, or present opportunities for extending the reach or range of services offered;
- ✦ **Organizational and human resource development**—Designing organizational structures and relationships to support achievement of the organization’s mission and strategic objectives; developing appropriate management skills at all levels; and developing and managing personnel systems that empower, support, and reward effective goal-oriented behaviors;
- ✦ **Management information systems**—Capturing information about the organization’s financial and service operations, and analyzing and acting on that information in a timely and effective manner.

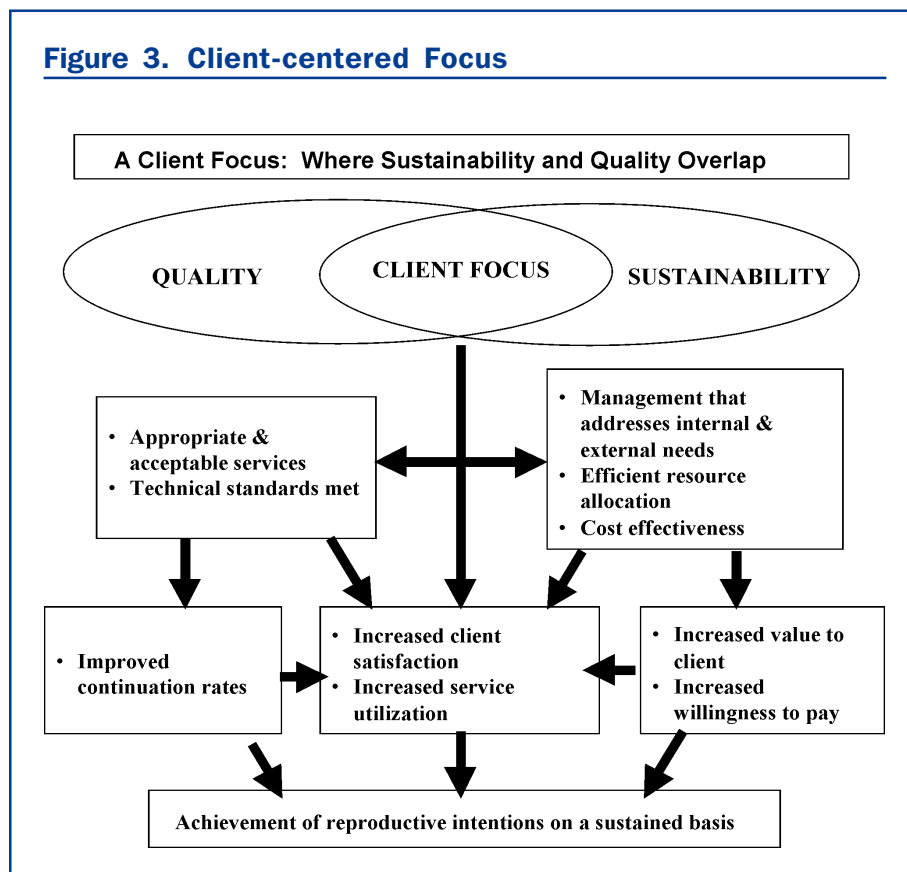
The specific activities that SEATS supported to enhance these capacities in each of its partner organizations are presented in Table 3 on page 13.

### Client-centered—Focused on service delivery

SEATS’ approach to sustainability recognizes that everything an effective partner organization does—from delivering services to populations in need, to approaching local and international donors for various types of support—is done with the client in mind. The project’s efforts to enhance the institutional capacities of its partners were shaped and driven by this client-centered focus. The objective was not to further develop a capacity for its own sake—to better approximate some ideal notion of what a partner should do, or what it should look like—but to provide services that meet client expectations and that the clients perceive to be of value in meeting their—not the organization’s—needs. This approach overlaps with SEATS’ quality strategy, which also places the client in the center of the process (see Figure 3 on the following page).

This client-centered approach to institutional strengthening for reaching underserved populations was demonstrated in the project’s special initiative—Midwifery Association Partnerships for Sustainability (MAPS). Implemented by the American College of Nurse-Midwives (ACNM), this program helped to develop and maintain high standards and expand the

**Figure 3. Client-centered Focus**



services provided by professional midwives' associations in four African countries—Senegal, Uganda, Zambia, and Zimbabwe. This effort entailed building the associations' capacities for self-governance, management, training, advocacy, diversification of funding sources, strategic planning, and marketing. The program also worked with member midwives to enhance the sustainability of their services by providing them with basic business skills, community mobilization training, and experience in client-centered, continuous quality improvement. MAPS integrated its quality and sustainability approach by placing a client focus at the center of each. A more detailed description of SEATS' experience under MAPS is provided in Annex II.

## Flexible—Reflects level of development and operating environment

SEATS' approach varies according to its partners' level of development and operating environment. For example, organizations operating in countries such as Cambodia, where the problems of underdevelopment are particularly severe, face a different funding market than in countries such as Turkey. Cambodia still has a highly subsidized market, with almost half of government expenditures covered by external financing. It continues to be ranked by bilateral and multilateral donors as one of the neediest countries, and these agencies will continue to be a major source of support for Cambodian organizations in the foreseeable future. Other factors that affect SEATS' approach include age and capacity of the organization, the general economic situation, the contraceptive prevalence rate, and incidence of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) and maternal mortality. Table 1 shows the different types of SEATS partner organizations, and the key characteristics of the countries within which they operated.

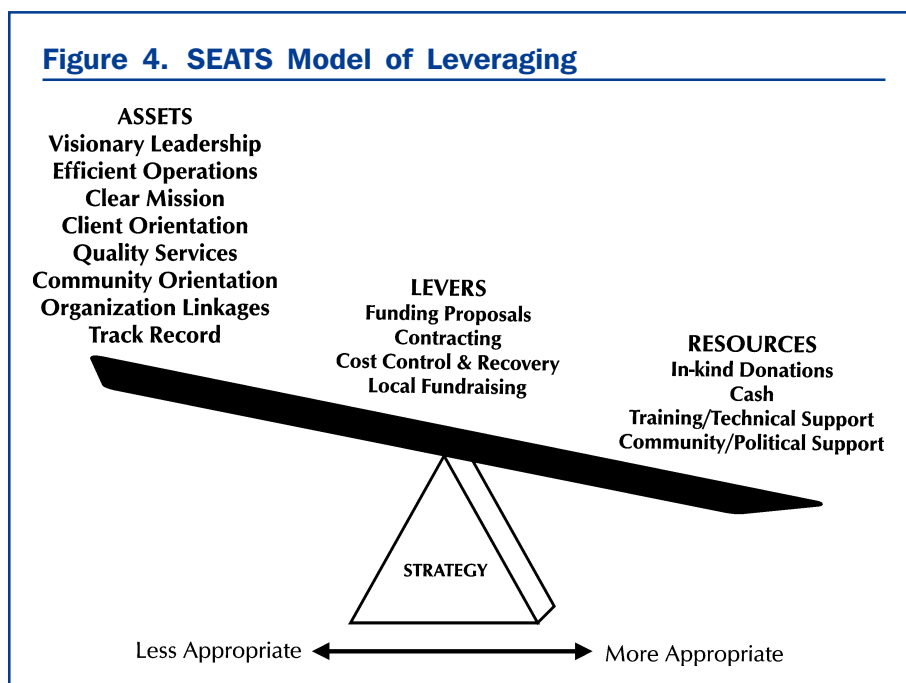
**Table 1. SEATS Partners**

Country or Program Characteristics	Number and Type of Partner Organization			
	Public Sector	Private NGO	Private Provider	Total
<b>War-torn, emerging from war</b> Albania, Cambodia, Eritrea, Mozambique	4	7	2	13
<b>Extreme Poverty (per capita GNP &lt;\$400)</b> Cambodia, Eritrea, Kyrgyz Republic, Mozambique, Uganda, Zambia	3	7	3	13
<b>Mature Family Planning Program</b> Russia, Turkey, Zimbabwe	6	2	1	9
<b>Adolescent Program</b> Cambodia, Eritrea, Mozambique, Senegal, Uganda, Zambia, Zimbabwe	8	9	1	18
<b>High HIV Prevalence</b> Cambodia (highest in Asia), Mozambique, Uganda, Zambia, Zimbabwe	4	9	3	16

## Realistic—Seeks a balanced mix of international and local resources

Developing a mix of international and local resources is central to SEATS' leveraging approach. Given the difficult economic environments in which its local partners operate, international funding is critical in the short and medium term. However, as the availability of international funding shrinks, transferring the funding of subproject operating costs from one donor to another is not an appropriate approach for the long-term sustainability of reproductive health services. Local leveraging activities, therefore, are important to include in any approach to enhancing long-term sustainability. While diversifying a partner's donor base is a good strategy for lessening its dependence on a single donor and increasing its autonomy, it should be coupled with building its capacity to increase local earnings.

As a means of enhancing sustainability and increasing independence, SEATS has assisted its partners to leverage local and international resources. Figure 4 illustrates the SEATS approach to leveraging.



Various tools and techniques can serve as the “levers” by which an organization’s existing or enhanced assets (listed on the left side of the lever) can “leverage” additional resources (shown on the right side of the lever). Examples of leveraging tools are: cost recovery systems that include some form of user fees; proposal development; contracting; and cost-saving measures that make service delivery more efficient.

The effectiveness and efficiency of an organization’s leveraging efforts depend on the strategy and combination of tools it employs, i.e., the position and size of the fulcrum beneath the lever. The more appropriate the choice of strategy and tools—the better they “fit” or reflect the organization’s mission, actual strengths, resource needs, and operating environment—the greater the contribution they can make to the likely success of the leveraging process.

## Programmatic Activities

SEATS undertook a wide range of activities at the headquarters, regional, and subproject levels to enhance the sustainability of its subproject partners. Key activities at each of these levels are highlighted on the following page.

## Headquarters Activities

- ✦ **SEATS Plan for Sustainability and Cost Recovery:** SEATS developed its *Plan for Sustainability and Cost Recovery: Guidelines for Strengthening Institutions and Recovering Costs* in order to support headquarter and field staff efforts to incorporate sustainability into project design and implementation. Approved by USAID in 1997, the Plan provided a framework for SEATS sustainability activities—the contextual considerations that shape individual approaches to sustainability, the institutional and financial elements to be addressed, and formats for sub-project sustainability plans and their monitoring. SEATS introduced the Plan to SEATS staff members through a two-day workshop in Washington, followed by a one-day session in the Africa Regional Office.
- ✦ **Guide to User Fees:** Originally developed under SEATS I, a two-volume guide on *Designing and Implementing User Fees* was produced and disseminated under SEATS II. The first volume discusses issues and considerations related to implementing user fees, and the second works through the various steps involved in designing a fee system, including worksheets for pricing family planning services.
- ✦ **The SEATS II Guide to Leveraging:** Developed to provide a comprehensive, but not exhaustive, overview of leveraging, the purpose of the *SEATS II Guide to Leveraging: Mobilizing and Diversifying Resources for Reproductive Health* is to assist reproductive health organizations in analyzing, designing, and implementing strategies to mobilize the additional resources they need to maintain or expand their program services.

## Regional Activities

SEATS approached sustainability differently in Africa and Asia/Near East (ANE), given the diverse policy and programmatic environments in these two regions.

Assistance within the Africa region went to a diverse group of family planning organizations. Many were part of established and experienced national family planning programs, such as one or two hospitals or clinics within a municipality. In these cases, although FP services had been provided for many years, sustainability had not been addressed or articulated from the beginning of the services. Consequently, under SEATS, sustainability became a new initiative to be incorporated into their operations. These sustainability initiatives were, in most cases, combined with service quality improvement activities. Key regional level activities with African partners included the following:



- ✦ **Quality and Sustainability Workshop (August 1997).**  
A week-long workshop was held to facilitate the development of sustainability strategies and activities by each participating country/subproject. Following this workshop, SEATS conducted country-level workshops in Zambia and Zimbabwe so more subproject partners could participate.
- ✦ **Opportunities Industrialization Centers (OIC) International NGO Sustainability Workshop (April 1998).** SEATS sponsored the participation of its six NGO partners and three SEATS regional staff at this workshop, and facilitated one of nine workshop groups. More than 200 delegates from Africa participated in the workshop, leaving with a plan on how to share what they learned at the workshop with their colleagues back home.
- ✦ **Leveraging Workshop (March 1999).**  
This ten-day workshop held in Harare was designed and conducted to facilitate the development of leveraging strategies by participating organizations, and to contribute to the development of the SEATS leveraging guide. Representatives from seven SEATS partner organizations in southern and eastern Africa participated in the workshop. Each produced an action plan for leveraging resources to support its identified needs.

Assistance within the ANE region involved private organizations and public services that were either newly formed or that had limited capacity in providing reproductive health services. For example, the Albania Ministry of Health had never provided contraceptives because they were previously illegal, and in Cambodia, little or no contraceptive services, either public or private, had existed. Accordingly, sustainability elements were incorporated more fully into the basic growth strategies of the organizations—SEATS focused primarily on institutional capacity building as these organizations built up their family planning capacity, the diversity of the method mix they offered, and the skills of their health professionals. Given the programmatic diversity and geographic distance between the SEATS ANE subprojects, SEATS did not conduct any regional-level activities for its partners in these countries.

### Subproject-level Activities

**Sustainability Plans:** SEATS assisted each of its subproject partners in developing and implementing a sustainability plan that addressed its particular needs and sustainability objectives. The plans covered a range of institutional and financial elements; these are summarized in Table 2. SEATS hosted several meetings where subproject partners came



together to review and update their plans to reflect changes in their organization and environment. Write-ups of each subproject's sustainability efforts, including copies of its plans, are available.

**Sustainability Workshops:** SEATS held sustainability workshops for PLAN/India and its local partner Community Aid and Sponsorship Programme (CASP)-PLAN and for a number of private voluntary organizations (PVOs) in Zambia, including World Vision. Each participating organization developed a sustainability action plan at the end of the workshop. Local consultants participated in the workshops and provided continuing assistance in implementing these plans.

**Technical Assistance:** At the subproject level, SEATS supported a wide variety of activities to help partners sustain their services and programs. Examples of the types of activities related to sustainability that were undertaken include:

- ✦ Assisting the Reproductive Health Association of Cambodia (RHAC) to identify potential donors, prepare proposals, and negotiate grant agreements;
- ✦ Designing a logo for RHAC that is used on new signboards for its clinics and on its information, education, and communication materials;
- ✦ Conducting an analysis of the costs of RHAC's key services;
- ✦ Designing and implementing an accounting system for the Uganda Private Midwives Association (UPMA) and training staff in its operation;
- ✦ Designing a fee system for the UPMA model clinic;
- ✦ Identifying potential income-generating activities for peer educators in Lusaka, Zambia and Gweru, Zimbabwe;
- ✦ Conducting market surveys for Kyrgyzstan Family Group Practices on client expectations and satisfaction;
- ✦ Developing a position paper on private midwifery services advocating a reduction of barriers to private delivery of reproductive health services by Zimbabwean midwives; and
- ✦ Preparing cash flow projections for a proposed polyclinic to be operated by the Independent Clinics Organization (ICO) in Zimbabwe.

A list of key technical assistance activities by subproject is provided in Table 3.

**Table 2. Sustainability Elements Matrix**

Subproject	Commodity Procurement/ Management	Marketing Capabilities	Diversification of Services	Strategic and Financial Planning Capabilities	Human Resources/ Training Capabilities/ Leadership	Community Involvement	Leveraging, Coordination with other programs or institutions and/or revenue generation	Presence of a Functioning Cost Recovery System	Financial Mgmt, Cost Containment, Efficiency Measures	Quality of Care/ Quality Improvement	Internal Policy Commitment
Albania	X	X	X		X		X	X		X	
Cambodia					X		X		X		
RHAC					X			X			
Midwives		X		X	X						
Eritrea											
MOH	X	X		X						X	X
NUEYS	X	X		X	X	X	X		X	X	X
Kyrgyzstan		X	X		X					X	
Mozambique											
TdH											
Save the Children					X		X				X
World Relief	X	X			X	X					X
HAI							X			X	
Russia											
Novosibirsk		X			X		X			X	
Primorsky Krai		X			X		X			X	
Senegal											
ANSFS				X	X					X	X
SANFAM	X	X		X			X				
ASBEF			X		X	X				X	X
Turkey - SSK	X			X	X				X	X	X
Uganda MAPS I & II		X	X	X	X		X				X
Zambia											
Lusaka Urban	X				X	X				X	
Lusaka Youth					X	X	X			X	X
ZNA MAPS				X	X	X					
Zimbabwe											
Chitungwiza		X	X		X		X			X	
Bulawayo VSC			X		X		X	X		X	
Bulawayo Training			X		X		X			X	
Gweru Urban		X			X		X		X	X	
Gweru Youth		X			X	X	X			X	X
ZINA MAPS		X	X	X	X		X	X		X	X

### Table 3. Sustainability Activities by Subproject

[illegible]



## Lessons Learned

### **Invest in planning and management capacity.**

The importance of this lesson cannot be overstressed. Perhaps the greatest constraint SEATS faced in working with partners to enhance sustainability was the limited time it had available for this purpose—typically less than two years. Pressure to get services operational as quickly as possible limits the extent to which the capacity-building efforts with partners can be undertaken. When too many activities are planned, the partner’s ability to adopt and digest the assistance is hindered. In many subprojects, SEATS built some sustainability factors into the design (e.g., no funding of recurrent costs), but focused initial technical assistance on strengthening and expanding the services. As a result, direct management- and finance-related capacity building fell toward the end of the project, often with little time remaining. While this responded to the need to increase access to quality services in a limited time frame, it may have hindered the subproject’s ability to sustain its programs after SEATS’ departure.

Given enough time, significant institutional development can be achieved. Consider the SEATS collaboration in Cambodia, where its assistance to RHAC was sustained for nearly three years, supplemented with additional USAID Mission financial resources, and guided by a long-term Resident Advisor. The initial focus on institution building—strengthening its basic management, financial, and marketing operations—proved an extraordinarily fruitful investment. Because of this, RHAC was able to expand the scale and reach of its operations, e.g., quadrupling sexually transmitted infection (STI) and antenatal care visits over 1996 levels by the end of 1998, and to achieve its 2001 leveraging target of reducing USAID support to 60 percent of total costs by the end of 1999, two years ahead of schedule. Annex I provides a more detailed description of this experience.

Alternatively, an example of what can be done within the constraints imposed by inadequate time frames is SEATS’ collaboration in Senegal. There, USAID/Senegal requested that SEATS assist a Senegalese NGO (Santé de la Famille—SANFAM) to meet the PVO registration require-

Dedicated resources to increase and improve institutional—not just service delivery point—capacities to plan and manage development resources are fundamental to enhancing sustainability.

ments. This request came with less than nine months remaining in the subproject agreement. With SEATS assistance, SANFAM developed a solid business plan that outlined approaches to increase local income, improve financial management, and diversify its funding base. But implementation and achievement of its financial break-even point for its income-generating activities will most likely take several more years.

Less dramatic, but no less important for sustainability, SEATS encouraged its partners to think as social entrepreneurs—identifying ways to circumvent constraints and threats to their continued provision of quality services that arise in constantly changing operating environments. For example, in both a Zimbabwe private clinic and the Lusaka Youth subproject, SEATS partners demonstrated their ability to turn a threat—declining service statistics—into an opportunity to learn more about their clients and improve their services. But, to the extent that such adaptive behaviors are relatively new, developing these capacities also takes time.

### **Manage the inherent tensions among rapid service expansion, service to the poor, and long-term sustainability.**

A need to move rapidly in promoting the expansion of services is not always compatible with requirements to achieve long-term sustainability. There are trade-offs, and the poor are especially vulnerable to the consequences of this conflict.

Some parts of a sustainability program's design can impede or misdirect expanded access to services in the short term. Sensitivity to such unavoidable tradeoffs during the design stage can help to limit their more negative consequences for organizations and their clients. Consider the following examples of such tradeoffs from the SEATS experience:

- ✦ Nonsupport of recurrent costs avoids excessive donor-dependence. The tradeoff here, however, is that it can also limit donor agency participation in decisions on how and where a partner organization's staff resources will be assigned. For SEATS, this has often resulted in frequent transfers of a partner's trained staff, thereby limiting the expansion of services.
- ✦ Diminishing or nonsupport of commodity procurement and other supplies similarly established the partner organization's responsibility for these inputs. The tradeoff here is that local funding is not necessarily more reliable than that provided by external donors. For SEATS, local political and economic developments that limited or disrupted local funding commitments resulted in stock-outs of key commodities and supplies that worked against achieving programmatic objectives.
- ✦ Provision of capital equipment can be a key input for enhancing the quality or effectiveness of the partner organization's administrative and programmatic operations. But again, local funding for either maintenance or replacement costs may be less reliable

than externally provided support, particularly if the equipment does not generate a new or enhanced revenue stream. Such maintenance and replacement costs strained a number of SEATS partner organizations, diverting their limited resources from programmatic uses.

- ★ Client fees can be an important part of an organization's sustainability program, but they raise the risk of denying service access to low-income groups included in the organizational mission. Several SEATS partner organizations addressed this issue, but none more dramatically than RHAC. Client fees were an essential part of RHAC's objective of reducing its dependence on donor funding. As a percentage of that organization's operating expenses, client fees and program income grew from 12 percent in 1997 to 16 percent in 1998. But this success ran counter to the high priority RHAC placed on ensuring access to quality services to the poorest segment of the population. Surveys of RHAC clients revealed them to be from better-off socioeconomic groups. Other studies indicated that people living in the very poorest areas of Phnom Penh were unaware of RHAC's services and unable to pay for services. Consequently, RHAC management scaled back its revenue objectives from client fees, and moved to offer more free care and encourage those from the very lowest socioeconomic level to visit RHAC's clinics.

World Relief Corporation (WRC) in Mozambique provides an example of how the tensions between expanding access, sustainability, and serving the poor were managed, leading to an enduring source of reproductive health services. WRC/Mozambique had been implementing a child survival project in the Gaza Province for several years. Its child survival strategy included extending the provision of services to the entire project area by training a cadre of village health workers—called *socorristas*—to provide services such as treatment for malaria, distribution of oral rehydration salts, and treatment for minor wounds at fixed health posts. The child survival strategy had aspects that made it inherently sustainable—the Ministry of Health (MOH) provided commodities and was responsible for supervision of the *socorristas*, and the *socorristas* received a fee-for-service from each client. WRC expanded the program to include family planning services. It did this by training *socorristas* to provide family planning services. But unlike other care, family planning services would be free. By expanding services through *socorristas*, who are already being paid, WRC was able to expand access to family planning from 54 to 98 percent of the population within 5km of services while maintaining the integrity of its project strategy.

## Sustainability issues are effectively addressed through the continuous quality improvement process of team-based problem solving.

The ability to respond effectively to a rapidly changing environment is a hallmark of organizational sustainability. This organizational capacity can be enhanced by the same data-driven team-based approach used for the continuous improvement of service quality.

SEATS' MAPS Initiative used CQI strategies to ensure the quality of the reproductive health services provided by its partner organizations. It is a methodology that enables staff at all levels to function as a team, analyzing the systems and processes in which they work and using the information to design and implement activities to improve the program services they provide. It is data-driven and client-oriented. The extent to which this methodology becomes part of the everyday working methods of an organization, however, can also enhance its ability to respond to environmental challenges not directly related to actual service quality.

**Figure 5. Houghton Park Private Clinic Letter to Clients**

*"Dear valuable client,*

*Houghton Park Clinic wants you back. Pills are only Z\$15 per packet. This may sound expensive, but if you buy elsewhere...You need to catch a lift, imagine the stress of waiting...the queue at the public clinic.*

*By the end of the day, you will have paid Z\$20 and four hours of stress. You could save this by walking to HP where you get served coffee, tea or a cold drink while you wait. Or watch the 6 o'clock news on our TV. Time spent is less, amount paid only Z\$15."*

The experience of the Houghton Park Private Clinic in Harare, run by one of the members of the Zimbabwe Nurses Association, illustrates this relationship between the CQI methodology and an effective response to external challenges. Increased costs of oral contraceptives resulted in client complaints about the price increases, and in a decline in family planning clients over the four months following the introduction of the higher pricing. The clinic's quality improvement team conducted a client survey. The survey revealed that although clients were happy with the services provided by the clinic, they preferred to purchase their oral contraceptives from public-sector sources at half the private-sector price. The clinic sent letters (see Figure 5) to its clients demonstrating that adding such hidden costs as transportation, waiting time, and stress to the public-sector price made the actual cost of the oral contraceptives from that source more expensive than those they could obtain from the clinic. This response proved effective—family planning client volumes returned to levels achieved before the price increase.



## Access to contraceptive commodities is critical for program continuation.

Client-focused sustainability efforts typically strive to increase service quality as a key means of enhancing the demand for, and use of, family planning and reproductive health services among intended populations. Access to low-cost family planning supplies is an important criterion used by clients in judging the quality of the services offered. Disruption of such access can quickly undermine other parts of an organization's sustainability program and work against achieving its objectives.

As external donors seek to transfer responsibility for funding commodity supplies to local authorities, they need to give explicit attention to the risks this poses for the ongoing sustainability programs of the organizations likely to be affected. Typically introduced as one part of a larger health-sector policy reform process, the actual transfer of responsibility is a high-risk venture, and its effects can quickly spread beyond the public sector.

Zimbabwe provides a good example of a mature program that was still threatened by a proposed end to donated commodities. While Zimbabwe has one of the highest contraceptive prevalence rates in Africa, it was dependent upon donors to provide contraceptives. Donors began phasing out their support of commodities, and the public-sector family planning agency, Zimbabwe National Family Planning Council (ZNFPC), stopped supplying the private sector and instituted charges for municipalities. This rippled down to private midwives, who were not permitted by the Drug Control Authority to procure and dispense contraceptives once ZNFPC stopped offering them. A number of midwifery practices closed, while others developed referral systems and relations with physicians to get around the restrictions. An example of how this affected an innovative midwifery practice is provided in Figure 6. Given the scale of the current HIV/AIDS epidemic, donors are reviewing their phase-out of support. This may be an effective short-term response, but there remains a need to develop a long-term strategy.

One of the critical parts of any FP/RH program is the steady supply of contraceptives; although it is often heavily donor dependent, it is frequently overlooked in sustainability planning efforts.

### Figure 6. Impact of the End of Donated Commodities on Rural Services

A midwife in a rural area of Zimbabwe ran two clinics in farming communities. Based on comments from clients, she began outreach activities, traveling to large communal farms weekly to provide basic services including antenatal care, STI diagnosis and treatment, HIV counseling, family planning counseling and services, basic laboratory, and minor curative care. Both the farmers and the farm workers found the services valuable: the workers did not have to lose a day worth of wages and the farmer did not lose his laborers. Other farmers began approaching the midwife to expand her outreach to their farms.

Unfortunately, the outreach services came to an abrupt end once donated commodities were no longer available through ZNFPC. The District Medical Officer would not let her dispense drugs and commodities without a physician present and told her she had to stop her mobile clinic. The farmers appealed the decision, but it held. More than a year has passed and the farms remain interested in the resumption of the mobile services. Due to lobbying efforts of the midwifery association, the MOH has verbally ended the restrictions, and written authorization from the Drug Control Agency is anticipated in early 2000. The midwife is already planning her first mobile visit.

In Turkey, SEATS was clear that donated contraceptives provided to the Turkish Social Security Agency (SSK) would be discontinued when the subproject ended. To convince SSK decision-makers that the purchase of commodities was a valuable investment, SEATS conducted a cost-benefit study that demonstrated a savings of nine dollars for every dollar spent on family planning. SSK executives proceeded to include funds in their budget for the procurement of contraceptives and bought their own commodities as of 1996. Subsequent changes in SSK leadership, coupled with budget reductions following a national economic downturn, delayed procurement, however, and by late 1997 there were systemwide shortages of intrauterine devices (IUDs), oral contraceptives, and condoms. The inevitable decline in the level of contraceptive use among SSK clients quickly followed. Even more serious for the system's long-term sustainability was the demoralizing effect this experience had on the professional staff's ongoing quality improvement program. (See Annex III for a more detailed description of this experience.)

### **Public-sector and adolescent programs require special approaches to sustainability.**

#### **Public-sector Programs**

The limited policy, administrative, and financial autonomy of public-sector reproductive health providers requires sustained technical assistance to identify and develop untapped local resources that can enhance program sustainability. Adolescent reproductive health programs require approaches to address the special challenges of working in the particularly sensitive area of adolescent sexuality with clients having limited or no income.

SEATS typically worked directly with service delivery points. In the case of public-sector providers, this often meant partnering with clinics and hospitals operated by municipalities. As a result, SEATS' range of sustainability efforts was limited to those areas in which the health facility had direct control.

Approaches that worked best were simple and practical—they provided targeted technical assistance and training in a number of areas: strategic planning; the use of data for monitoring and revising programs; financial management; logistics management; diversification of funding sources; and marketing in its broadest sense—understanding client demand and tailoring services appropriately.

Particularly important were activities that sought to identify and mobilize underutilized existing resources and new, unconventional resources. In Senegal, for example, retired health workers were engaged as health advisors to mayors. In Zambia, the recruitment and training of adolescents as peer educators to conduct advocacy activities in their churches, schools, and other community sites led to dramatic increases in service utilization by young men and women. (A description of the youth program in Zambia is provided in Annex IV.)

Opportunities to leverage additional resources as part of a larger sustainability plan were similarly limited for public-sector service providers. Municipal health facilities receive their budgets from city councils. All fees earned go directly to city treasuries and are not always available to support reproductive health services. In these cases, SEATS and its partner facilities can neither set fees nor improve the financial management of the city treasury. A related issue is that of government or donor requirements, which require public and private organizations to go through the Ministry of Health or Finance to receive outside funding. Often, requests for funding or letters of support are stalled by bureaucratic red tape.

Again, SEATS used relatively simple and practical approaches to facilitate the use of leveraging as an approach to enhancing the long-term sustainability of some of its public-sector partners. In Senegal, for example, SEATS facilitated the formation of coalitions of municipal officials, health authorities, and private-sector partners that were able to advocate for additional local and international resources to support high-priority reproductive health services. Technical assistance focused on data-driven decision-making—providing local public authorities with the planning and proposal development skills needed for leveraging additional resources. (See Annex V for a brief description of leveraging activities undertaken as part of SEATS' Urban Initiative.)

## Adolescent Programs

Adolescent reproductive health programs not only face the challenge of developing political and community support for a sensitive area, they also serve young people who have limited financial resources to pay for services. Those programs that use peer educators, an approach SEATS found to be effective in reaching youth, must also address the need to continually train peer educators as they age out of the peer group, and to balance peer volunteerism with the need to earn income in an extremely poor environment.

Adolescent reproductive health programs, then, present special challenges that require special, youth-sensitive approaches:

- ✦ Advocacy to win support of political leadership and commitment of resources to pay for the services;
- ✦ Community mobilization to develop an understanding of the need for adolescent reproductive health services; and
- ✦ Alternative income generation for peer educators.

In the Lusaka Youth project, for example, SEATS was successful in building support for adolescent services within the community and at the municipal level, using a participatory, data-driven approach. The peer educators were also able to generate some limited income from selling newsletters, renting out space at a donated building, and showing videos for a fee. However, this income was not sufficient to address the pressure they felt from their families to contribute to the family income. Within six months of the end of SEATS support, half the peer educators had either dropped out of the program or significantly reduced the time they spent on program activities. While the clinic-based adolescent services continue, and the district health management team and the neighborhood health committees remain committed to adolescent reproductive health services, additional opportunities to provide some financial support for the peer educators need further exploration.

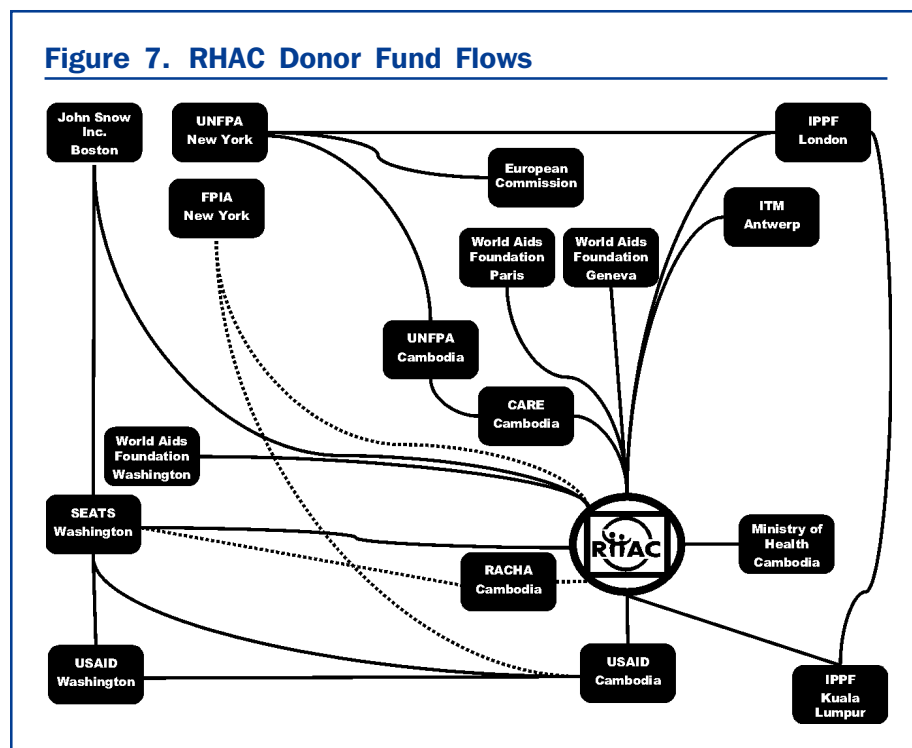
### **Successful leveraging of additional resources can also create new organizational challenges.**

Relationships with multiple donors can be complex. Often, funds from one donor will flow through several channels, making it difficult for the recipient to know whom to contact about different aspects of programmatic and administrative operations. Responding to their requirements may distract the organization from focusing on its core mission activities.

Multiple donors can create significant administrative burdens for the recipient organization. Different donors typically have different reporting requirements for content, format, and timing. Lines of communication can be as varied and as complex as the different organizational structures and political mandates of the various donors. Effective management of such increased demands inevitably translates into additional costs to the organization. Such costs can range from the demands made on management time to the increased recurrent costs due to upgraded administrative systems and additional staff.

These are the challenges that confronted RHAC, which expanded its number of donors from two to nine within little more than one year. As Figure 7 on the next page shows, RHAC's relationships with its multiple donors became increasingly complex. For example, RHAC's United Nations Population Fund (UNFPA)/European Commission (EC) grant is funded jointly by the EC and UNFPA. The EC funds must be made available through a European organization, in this case, International Planned Parenthood Federation (IPPF). All these organizations have either regional or country offices that also interact with RHAC. The result is that their requests for information often originate from several levels, increasing the reporting burden and confusing channels of communication.

**Figure 7. RHAC Donor Fund Flows**



Responding both to these requests for information and to the need to communicate more frequently with multiple funding agencies to clarify and establish common understandings reduced the time that senior staff had to devote to internal program planning and management. This can also distract their attention away from RHAC's core mission of providing RH services to underserved Cambodians.

Furthermore, with each additional donor grant and clinic established, RHAC's financial management became more complex. Accurately tracking income and expenditures by funding source and producing the required reports with its existing manual system became highly labor intensive.

To better manage or respond to multiple donor demands, RHAC strengthened its financial planning and management capacities through increased staff skills, improved accounting and audit systems, and enhanced understanding of its cost structure. RHAC also carefully weighs each opportunity to add to its donor portfolio and negotiates with the donors to minimize reporting requirements.



## *Building on the SEATS Experience*

Some clear directions for enhancing sustainability are indicated by what has been learned through SEATS.

First, and foremost, future efforts to enhance the sustainability of public and private providers of reproductive health services must ensure adequate time for capacity-building efforts. Efforts to enhance the sustainability of existing organizations frequently must work against or reverse management orientations and behaviors developed over years—for some, decades—of experience with donor-dependent development efforts. Such basic changes require sufficient time for intensive work with organizational leaders. Younger organizations need sustainability assistance that develops their organizational direction and systems, which also takes time. Consequently, a commitment to enhance the sustainability of one's implementing partners may mean accepting that tangible results in terms of increased financial autonomy and the expansion of quality services may not be realized during the life of the project through which the technical assistance is being provided. To do less is to promote the appearance of a sustainability program, but not its substance.

In practical terms, this means emphasizing low-cost expansion approaches such as outreach, when this is possible and practical, over increasing clinic sites and expensive technology, which adds recurrent management and financial costs that may significantly extend the time frame for realizing the organization's sustainability goals. It also suggests that programmatic flexibility that allows support for initial recurrent and capital costs incurred in expanding services to underserved populations should be weighed against an implementing partner's ability to absorb the costs in the future. This, in turn, will require careful medium- and long-term planning, and sufficient time to support the partner's sustainability efforts.

Second, the SEATS experience has shown that although there is no one approach that will work in all settings, there are sustainability activities that do work. The key is to plan activities around a clear understanding of the specific context within which a partner organization operates, and to consider the widest repercussions—both positive

and negative—that result from implementing each activity. Developing services that are of value to the clients and the community should be a cornerstone of all sustainability efforts. Tailoring affordable and accessible quality services to address client needs can increase intended clients' willingness to pay for services, increase their use of the services offered, and improve their contraceptive continuation rates.

Third, continuous quality improvement of management and service delivery operations is important not only for its own sake, but also for the contribution it makes to the long-term sustainability of the organization. The emphasis CQI places on data-based, client-centered, team decision making represents a basic organizational capacity to anticipate and respond effectively to an ever-changing operating environment.

Fourth, client populations must be appropriately segmented by their ability to pay for services. Employer-based services, public-private partnerships, private-sector entities, and avenues that tap diverse market segments have shown promising results and need to continue to be explored and developed. The SEATS Urban Initiative in particular offers numerous examples of mayors and other municipal officials who built partnerships with the private sector as a means of increasing the access of the working poor to health education, and of including them as active participants in needs assessments.



# Annex I:

## Institutional Development in Cambodia—RHAC

### Background

The Reproductive Health Association of Cambodia (RHAC) is a relatively young organization. It grew out of the USAID-funded Family Health and Spacing Project that was managed by Family Planning International Assistance (FPIA) from 1994 to 1997. With USAID encouragement, RHAC registered in 1996 as an indigenous, not-for-profit organization managed and staffed by Cambodians. In early 1997, USAID/Cambodia continued its financial and technical support of RHAC through SEATS as the RHAC Service Expansion and Institutional Development Subproject.

When RHAC registered as an NGO in 1996, it had two clinics, one in Phnom Penh and one in Sihanoukville. Each clinic had a network of community-based Health Development Team (HDT) workers. RHAC also supported the public sector in three of 21 provinces in the delivery of clinic- and community-based services. The clinics provided antenatal care, information, and counseling on HIV/AIDS, laboratory services, and diagnosis and treatment of reproductive tract infections, including sexually transmitted infections (STIs). In addition to these reproductive health services, RHAC also offered a full range of family planning methods to its clients—condoms, oral contraceptives, IUDs, implants, injectables, and sterilization.

The RHAC story illustrates the fundamental relationship between an organization's institutional capacities and its success in moving toward its sustainability goals. SEATS' inputs were wide-ranging, intensive, and sustained over several years. The focus of its technical assistance was on strengthening basic management, financial, and marketing operations. The result was the significant growth and diversification of the organization's resource base, and a dramatic increase in the range and reach of its reproductive health services.



*While focusing on institutional capacity building, RHAC has also expanded access to reproductive health services in Cambodia.*

## **From Dream to Reality—Investing in Institutional Development**

When SEATS began working with RHAC in 1997, RHAC did not have an articulated mission statement or a strategic plan. Its organizational structure was still that of an FPIA project, and its financial systems were based on the system used to track FPIA's project funds. RHAC was almost solely dependent on one donor—USAID—for its income.

From the outset of its collaboration with RHAC, SEATS focused on helping RHAC's management to think strategically—to routinely examine issues from every angle—and to do so as a continuous process of understanding and adapting to a constantly changing environment.

SEATS conducted a four-day strategic thinking and planning workshop as a first step toward developing RHAC's organizational capacities. During the workshop, RHAC staff reviewed the organization's purpose and objectives and drafted a mission statement. They also conducted a stakeholder assessment, and an analysis of its strengths, weaknesses, opportunities, and threats to better understand their organization and its environment. The outcome of this process was the identification of key organizational priorities and the development of a strategic plan for achieving RHAC's service expansion objectives. Together, these formed the framework for a comprehensive program of institutional strengthening undertaken in collaboration with SEATS.

The key priorities identified during the strategic planning workshop were:

- 1) Strengthening RHAC's financial planning and management
- 2) Improving its information, education, and communication (IEC) and marketing capacity
- 3) Developing a comprehensive leveraging strategy as a cornerstone of its sustainability plan

### **1. Strengthening RHAC's Financial Planning and Management**

Technical inputs focused on three broad areas: increasing staff skills, improving accounting and audit systems, and developing a better understanding of the organization's costs. Among the more significant activities were:

- ✦ Staffing up the accounting function with an accountant and an accounting assistant, and conducting accounting and finance training courses for senior managers;

- ✦ Reconstructing the manual accounting system, preparing a financial planning and management manual that included establishing a comprehensive chart of accounts, developing multiyear budgets, and conducting an external audit of annual financial statements; and
- ✦ Carrying out a detailed cost analysis of RHAC's service delivery operations.

## 2. Improving IEC and Marketing Capacity

Technical inputs focused on three areas: developing in-house IEC/marketing expertise; assessing options for local outsourcing of selected design and production activities; and developing an in-house market research capacity. Among the more significant activities were:

- ✦ Assigning three staff to the IEC/marketing function and giving them appropriate training, particularly in the research, development, and testing of messages and materials;
- ✦ Hiring a local design firm to develop RHAC's organizational logo for use in all its facilities and materials, and to redesign its family planning information materials; and
- ✦ Designing and using various research tools for profiling the socioeconomic status, attitudes, and behaviors of RHAC's current and potential clients, and for monitoring the services offered by other providers and the prices they charge their clients.

## 3. Developing a Leveraging Strategy

Technical inputs focused on three key areas: diversifying funding sources, increasing non earmarked revenues from user fees and training tuition payments, and finding alternative sources of support for core costs. Among the more significant activities were:

- ✦ Systematically assessing each opportunity to solicit donor funding against such factors as the potential contribution to RHAC's mission, the ability to address an emerging need, donor requirements, the amount or type of funding available, and restrictions on its use;
- ✦ Developing proposal writing skills, including English language training;
- ✦ Promoting organizational good will, trust, and solidarity—organizational “social capital”—that facilitates RHAC's networking and collaboration with other local and international organizations;

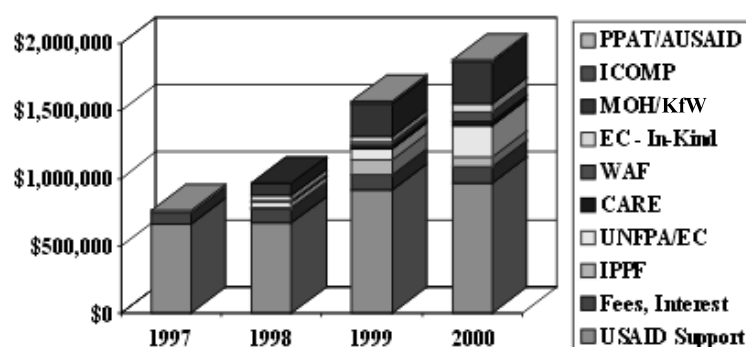
- ✦ Establishing a working capital fund with user fee revenues in order to create a capacity to improve capital assets, cover unanticipated losses, and meet operating costs in the event of a funding shortfall; and
- ✦ Including indirect costs in funding agreements with donors, which it allocates to a reserve fund for future support of programs following the inevitable withdrawal of USAID support of all core costs.

## Achievements

RHAC has emerged from this process of institutional strengthening as the strongest indigenous NGO in Cambodia's health sector and the leading private-sector organization in the field of reproductive health in Cambodia. The successful implementation of its leveraging strategy has reduced USAID support to 60 percent of the organization's total costs; more than a half-dozen new donors—local as well as international—now provide financial and in-kind support for various RHAC programs (see Figure 8).

RHAC has expanded from two to five clinics, with over 500 HDT workers providing outreach. RHAC's clinic staff are currently seeing approximately 25,000 to 30,000 clients per quarter; HDT outreach services accounted for nearly 100,000 family planning visits by 1998. Although RHAC is operating in only five of the country's 21 provinces, its family planning coverage is roughly one-third of the Ministry of Health's, and it provides commodities equivalent to about 30 percent of those provided through the public sector.<sup>1</sup>

**Figure 8. RHAC Sources of Support by Year**



<sup>1</sup> For more information on RHAC and SEATS work in Cambodia, see the SEATS publication: *Strengthening Reproductive Health Service Delivery in Cambodia*, by Janne C. Hicks, M.P.H., and Priya E. Mammen, January 2000.

## *Annex II:*

### *The Role of Client Perceptions—MAPS*

#### **Background**

The Midwifery Association Partnerships for Sustainability (MAPS) is one of five SEATS special initiatives designed to reach underserved populations. Implemented by the American College of Nurse-Midwives (ACNM), the MAPS Initiative is intended to contribute to the goal of increasing access to FP/RH services by supporting the development of midwives—both in their individual practices and their professional associations.

Beginning in 1995, MAPS developed and implemented subprojects in four countries in the Africa Region: Senegal, Uganda, Zambia, and Zimbabwe. In addition, MAPS has worked with midwifery associations in Cambodia, Eritrea, and Tanzania—supporting their initiatives, involving them in regional activities, and providing limited technical assistance on request.

The MAPS special initiative demonstrates that when properly trained and supported, midwives are dynamic forces for increasing access to high-quality, sustainable family planning and reproductive health services. The initiative works to increase the number of private midwifery practices; identify and support aspiring private practitioners; reach out to underserved populations such as men, youth, mineworkers, and farmers; expand the method mix; and improve referral systems. The basis for these achievements was the midwives' learning to improve their services by involving clients and their broader communities.

#### **The Approach**

The MAPS approach involves working with an existing midwifery or nursing association to design and implement a SEATS subproject that adapts and applies four key MAPS strategies to the specific needs of private-sector midwives and midwifery associations in the country. These strategies are:

- 1) Building the capacity of associations
- 2) Building the capacity of member practices
- 3) Creating a more enabling practice environment
- 4) Integrating quality and sustainability

## 1. Building the Capacity of Associations

Improving the capacity of midwifery associations strengthens the ability of individual midwives to provide high-quality services to their clients. MAPS assisted its partner organizations in three broad areas:

- ✦ *Member services*—Associations were encouraged to develop such tools as membership surveys and databases as a first step in meeting members' needs, to foster a sharing of information and experiences; to provide continuing education, seminars, and technical updates; and to develop training capability within the associations.
- ✦ *Coalition building*—Linkages have been developed between professional associations, key stakeholders, clients, community leaders, and providers of local, national, and international resources through such channels as association newsletters, journals, and, more recently, e-mail.
- ✦ *"South-to-south" collaboration*—The skills and resources of midwives from other developing countries are used (rather than only technical assistance from the North), as was done by using trainers from Uganda in the business management and community mobilization training provided to midwives in Zimbabwe.

## 2. Building the Capacity of Members

Training for individual members is the main activity of this strategy. In addition to local, national, and regional workshops to disseminate current updates on FP/RH service provision and on the sustainability of private midwifery practices, MAPS helped to position midwives as agents of change within midwifery training institutions, regulatory bodies, and such organizations as the East, Central, and Southern African College of Nursing (ECSACON) and the International Confederation of Midwives (ICM). Training curricula and continuing education materials developed, field tested, and put into use include: Business Management Skills for Private Midwives Curriculum; Community Mobilization for Private Midwives Curriculum; Handbook for Aspiring Private Midwives; standards for private-practice midwifery; and family planning referral guidelines.



Midwives received training (and trained others in turn) in capacity-building topics such as business management skills.



### 3. Creating a More Enabling Practice Environment

MAPS' strategy for creating more enabling practice environments included efforts to reduce significant barriers that keep midwives from offering integrated family planning and reproductive health services, and to develop guidelines for establishing standards for private practice and for referrals of clients to appropriate providers of such services as IUDs and voluntary sterilization. These efforts included facilitating dialogues between midwives and regulatory agencies, advocating for policy changes, developing position papers, and creating links with other organizations.

### 4. Integrating Quality and Sustainability

Efforts to improve quality and enhance sustainability center on the client. Providing services that meet client expectations and that are perceived to be of value improve the quality of services and the likelihood that they will be sustained. This requires an integrated approach to quality and sustainability—one that combines a process of continuous quality improvement, and the enhancement of sustainability based on team-based problem solving; the involvement of clients, community members, and midwives; and use of data in a cycle of planning, implementation, evaluation, and feedback.

This strategy was applied at two levels—the midwives as individual service providers and as members of their professional associations. For both, the focus was on enhancing their capacity to identify quality problems and to devise and implement solutions. An example of a midwife's efforts to improve her clinic's quality services for clients was cited earlier in this paper—the Houghton Park Private Clinic's letter to clients on the cost of pills (see page 18). The following is an example of this strategy applied at the association level:

#### Model Clinics/Zimbabwe

**Challenge:** Develop two model clinics to serve as practicum sites for aspiring private midwives and as models for currently practicing private midwives.

**Response:** Visits of potential clinics yielded six sites that met the criteria for selecting a model clinic. All six sites were chosen, and a Model Clinics Consortium was developed to manage the technical assistance needs of the six sites.

**Result:** The positive and empowering experience of working toward a common goal as members of a consortium led to the initiation of innovative activities, and, ultimately, the establishment of 18 model clinic sites located in strategic areas throughout Zimbabwe.

## Achievements

MAPS increased the capacity of midwifery associations to manage their operations and strengthen their members through training, the reduction of practice barriers, and the development and dissemination of private practice standards. By understanding member midwives' needs and providing the services they demanded, the associations were able to increase their membership. In Zimbabwe, the ICO increased its membership from 22 to 196 in less than three years.

MAPS was also successful in reducing practice barriers for midwifery private practice. In Zimbabwe, the ICO was able to negotiate with the Medical Aid Societies (social security) to cover services provided by midwives. It also prepared a position paper outlining the barriers to private practice and suggesting actions to take, and presented it at the Ministry of Health. The paper was well-received. The Permanent Secretary wrote a letter of support for private midwives and their association, the ICO. Also, the MOH initiated the process of eliminating restrictions on private midwives' ability to procure and dispense contraceptives.

MAPS' partners have leveraged non-USAID support from local and international sources. The Uganda Private Midwives Association (UPMA) received grants from the World Health Organization, UNFPA, Family Care International, and the World Bank. In July 1999, UPMA opened an association-run model clinic, which is projected to generate sufficient income to subsidize association operations within a year. In Zambia, the Zambian Nurses Association undertook a number of small income-generating activities. Some, such as renting out a set of flats owned by the association, were more successful than others, such as a failed attempt to operate a minibus.

Individual midwifery practices also enhanced their ability to sustain their services. Many now apply CQI to address issues relating to the quality and sustainability of their services. They place the client at the center of their services, which has increased use of their clinics and led to other income-generating activities. In Uganda, 90 percent of the midwives who completed the community mobilization training experienced at least a 10 percent increase in the use of their reproductive



health services. In Zimbabwe, as a response to client suggestions, midwives added additional services including day care, a beauty salon, and a fitness center to their clinical services. These now generate income for the midwives and attract new clientele.

Midwives also improved their business management skills. One midwife prepared a business plan for expanding her inpatient facilities and acquired a subsidized loan from the World Bank. She was later presented with the Zimbabwean “Business Woman of the Year” award. In Uganda, 92 percent of midwives who had completed the MAPS basic business skills training had instituted a system for basic financial records at their clinics.

These accomplishments, at the association and individual midwife levels, were built on the client focus that was pervasive throughout the MAPS subprojects. They demonstrate how a program can tap into and support an underutilized source of reproductive health services and build the capacity to sustain services.<sup>2</sup>

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<sup>2</sup> For more information on the SEATS II/MAPS Initiative, see the SEATS publication: *Expanding Access to Reproductive Health Through Midwives: The MAPS Initiative*, by Charlotte Houde Quimby, RNP/CMW, and Mary Lee Mantz, RNP/CMW, January 2000.



## *Annex III: Commodities and Sustained Quality in Turkey—The SSK*

### **Background**

Sosyal Sigortalar Kurumu (SSK) is the social security entity within Turkey's Ministry of Labor that administers a comprehensive package of pension benefits, disability and life insurance, and health care coverage for more than 30 million Turkish workers and their dependents—almost 40 percent of the country's population. It is the second largest provider of health services in Turkey, operating more than 100 hospitals and 300 outpatient facilities. In 1998, SSK facilities had 41 million outpatient visits, 1.1 million inpatients, and 222,500 deliveries.

The SSK story illustrates fundamental principles of the SEATS framework for quality of care in family planning and reproductive health: quality can be improved on a continuing basis—it is a process rather than an outcome—and it is best defined, promoted, and measured within a particular program. It also illustrates that such a process, while sustainable, cannot achieve its full potential in the absence of critical material supports, such as adequate supplies of family planning commodities.

SEATS' support of efforts to establish and expand comprehensive, high-quality family planning services within SSK's system of curative health care built on work done during 1992–1995 under the SEATS I Project. The wide range of technical and material inputs provided during that period to improve access to family planning information and contraceptive services achieved a fourfold increase in the number of contraceptive users. Also, the elements of a quality of care framework were put into place with the establishment of six training "centers of excellence" in SSK's largest maternity and general hospitals.

### **A "Bottom up" Approach to Quality Services**

SEATS' collaboration with SSK during the next three years, 1995–1997, focused on improving SSK management systems [strategic planning, human resource management, logistics, management information systems (MIS), and contraceptive self-sufficiency] that facilitate quality of care, while simultaneously carrying out a CQI initiative. This collaboration took the form of three workshops and ongoing technical support.

**Figure 9. Quality Improvement Projects at Ege Maternity Hospital**

- ✦ Improved patient records system
- ✦ Strengthened communications between the family planning unit and other hospital clinics and outside organizations
- ✦ Enhanced communication between the family planning unit and the hospital administration and technical equipment units
- ✦ Upgraded surgical sterilization services and operating room equipment

The six training centers mentioned above served as the sites for the CQI initiative. Each hospital formed a Quality Council and a Quality Team. The Quality Council, composed of administrators, had a management role—approving projects, assigning responsibilities, and monitoring the Quality Team’s implementation of the quality improvement projects. The Quality Team, which included frontline service providers and other employees directly involved in service delivery, used decision matrices, flowcharts, cause-effect diagrams, client flow analysis, tally sheets, and brainstorming to identify factors impeding quality and to propose quality improvement projects.

Each site implemented CQI somewhat differently. Some sites used the CQI tools, while others preferred a more informal brainstorming format to identify problems and propose solutions or projects. All documented the proceedings of their Quality Council meetings, facilitating subproject monitoring and follow-up. The flexibility of the CQI approach and its emphasis on site-specific conditions generated quality improvement projects that reflected the practices and priorities of each facility while also including most of the elements of quality of care. (See Figure 9 for an example of work done in one hospital.)

CQI processes such as Quality Council and Team meetings contributed significantly to staff morale and commitment to client-oriented quality care. Other technical improvements that increased access and service quality included a new logistics MIS, a strategic plan for SSK family planning services, standardized training curricula, national family planning service delivery guidelines, and new IEC materials.

### Commodity Shortages Undermine CQI

Reductions in USAID assistance to Turkey resulted in the discontinuation of the SEATS/SSK collaboration in early 1997. Although none of the CQI sites developed new quality improvement projects after the departure of SEATS, they continued to work on existing ones. These included in-service training for residents, development of new training materials based on their own experiences in CQI, family planning counseling for antenatal clients, outreach to adult literacy classes, and client satisfaction surveys (although resource limitations prevented carrying out the changes that the findings suggested).

Much more serious were the consequences of a systemwide stock-out of IUDs, oral contraceptives, and condoms in late 1997. The Turkish economic crisis reduced SSK’s budget, and a change in government resulted in the departure of SSK’s top family planning advocates. In the

absence of SEATS' ongoing policy, technical assistance to the SSK Board, the procurement of IUDs and oral contraceptives received little attention, and condoms were removed from the essential drug list. Consequently, SSK family planning clients who opted for the IUD, orals, or condoms received a prescription to obtain them outside the SSK facility. As word of the supply shortage spread among clients, demand for services dropped. By the end of 1998, SSK contraceptive users had declined to less than half the number of users in 1996; the proportion of clients visiting family planning centers who actually received a contraceptive method also declined—from 67 percent in 1997 to 41 percent in 1998.

The Quality Councils at the six “centers of excellence” stopped meeting. As one physician explained, “As there have been no commodities available in the system for nearly one and a half years, there is no practical value in continuing the Quality Council meetings. It is not possible to fulfill the requirements that are raised during the meetings.” At two sites, the Quality Council disbanded when new hospital directors, who did not support the CQI initiative, were named.

At most sites, family planning staff continued to act and interact as Quality Teams, demonstrating their deep personal commitment to the provision of quality services. The result of this continuing personal commitment to the values of the CQI initiative—and the bottom-up approach to its introduction—can be found in the quality scores of SSK facilities in the 1998 Quality Survey. Two years after SEATS' assistance ended, and after at least 12 months of commodity stock-outs, SSK hospitals ranked second to the MOH's maternal child health/family planning centers on an overall quality index, above the ratings of private hospitals, MOH hospitals, and MOH health centers. Nevertheless, despite the efforts of hospital Quality Teams, CQI could not increase the number of users in the face of budget cuts and continuing commodity stock-outs.<sup>3</sup>

<sup>3</sup> For more information on SEATS' work with SSK or the SEATS quality work, see the SEATS publication: *Mainstreaming Quality Improvement in Family Planning and Reproductive Health Services Delivery: Context and Case Studies*, by SEATS, January 2000.



## ANNEX IV:

### *Working With Youth in Zambia— The Lusaka Urban Youth Project*

#### **Background**

With SEATS technical support, the Lusaka District Health Management Team (LDHMT) set out to create “youth-friendly services” (YFS) to promote access and use of quality RH services for youth aged 10–24 years in seven project catchment areas in Lusaka. This effort included providing them with sexual and reproductive health information, and with appropriate contraceptive services, and encouraging non-sexually active youth to delay sexual intercourse.

#### **The Approach**

The approach focused on creating a supportive environment within which these services would be delivered—a “youth-friendly environment.” The approach combines clinic and community-based peer education and counseling services. More importantly, the young people themselves participated in a meaningful way in all stages of the sub-project—design, implementation, monitoring, and evaluation.

Three key elements instrumental in developing this supportive environment were:

- 1) Community involvement
- 2) Peer education
- 3) Health worker training

The Lusaka Urban Youth Project illustrates how a creative and sensitive approach to the special reproductive and sexual health needs of youth can facilitate their access to the services they want. The project developed, implemented, and tested a model combining clinic- and community-based peer education, and clinic infrastructure improvements that generated a positive response among youth, as well as other key stakeholders such as parents, community members, peer educators, and health providers. This community support provides a necessary base for sustaining the adolescent program. However, use of peer educators, while programmatically effective, raises several sustainability challenges, including a continual need for training new educators to replace those that age out, and for balancing their basic financial needs with volunteerism.

## 1. Community Involvement

Neighborhood Health Committees (NHCs) were created as part of the national health reform program in order to link clinics to their surrounding communities. Among their key contributions to the development of youth-friendly services are:

- ✦ Participation in the recruitment of peer educators
- ✦ Mobilization of the community and its institutions, particularly local churches, to participate in education and counseling of the youth in the areas of reproductive and sexual health
- ✦ Motivation of the adults within the community to talk to each other's children
- ✦ Fundraising
- ✦ Participation in clinic quality teams

## 2. Peer Education

A total of 20 peer educators were trained. Their training covered a wide range of issues related to sexual and reproductive health—their role as peer educators; human sexuality; basic facts, myths, and misconceptions about STIs/HIV/AIDS and their transmission; attitudes and values people have toward illness and sexuality; youth exposure to various risk factors; and the storage, distribution, sale, promotion, and use of condoms and foaming tablets.

The functions of the peer educators included, first and foremost, informing and educating other youths on sexual and reproductive health matters through “one-to-one” and group counseling sessions during their outreach activities and within clinic-based “youth corners.” This effort included motivating young people to use the youth-friendly services offered in the clinics, referring them for testing and services, and encouraging them to adopt positive sexual behaviors. In addition, the peer educators distributed condoms and foaming tablets.



*Peer educators met with youth both out in the community and in youth-friendly clinic corners.*



The peer educators also undertook a number of small income-generating activities, including washing cars, selling newsletters, renting space in a donated building, and showing videos for a fee. These activities provided some limited income, but were not sufficient to address pressures to contribute to family expenses.

### 3. Health Worker Training

Youth-friendly service training was provided to clinic health workers. Training involved sensitizing health workers to the special needs and concerns of young people in the area of sexual and reproductive health, and motivating them to support the development of a youth-friendly environment. Particularly important is the health workers' appreciation of the role of the peer educator, and their willingness to collaborate with peer educators in providing these services. Collaboration included providing peer educators with constructive feedback on their day-to-day activities, and guidance in addressing operational problems.

## Achievements

Initially implemented in two sites, youth-friendly programs had a positive impact on these clinics' ability to reach the youth in their communities—and led to the adoption of youth-friendly programs in other clinics in the municipality. The subproject's quarterly coordination meetings involving representatives from the health department, the Family Life Movement, and other international donors, are evolving into a mechanism for disseminating the advantages of this youth-friendly services approach to other service providers and community influentials within the municipality and the district.

The use of peer educators has been key to the success of these youth-friendly programs. The sustainability of such activities, however, cannot be assumed. Interviews with peer educators in the course of an evaluation of the subproject brought out a number of issues that would appear to work against the continued effectiveness of this activity. Chief among these was dissatisfaction with the level of support peer educators received with transport and lunch allowances for their community outreach activities. Dissatisfaction appeared highest where supervision and support by health workers was lacking. The peer educators faced considerable financial pressures to contribute to family household expenses or to cover their own expenses (see Figure 10). Within six months of the end of SEATS' support, over half of the peer educators either left the program or cut back on the amount of time they spent on adolescent services.

### Figure 10. Family Pressure

A father's view of his peer educator daughter working without receiving an allowance:

*"[My daughter] will not be coming to the clinic anymore. She has completed school and she cannot continue using my soap or other personal effects. She is old enough to buy hers. But why have you allowed SEATS project to use our children without even a small salary when the project has a lot of donor funds..."*

The experience with these peer educators points out their strengths and their weaknesses in representing a sustainable resource for reaching underserved adolescents. On the one hand, peer educators bring a dedication and level of energy that is vital for fueling aggressive outreach activities. On the other, they are a constantly changing workforce. Individuals leave the program as they receive alternative opportunities and, eventually, as they age out. Turnover among volunteers is inevitable, but it can be minimized and effectively managed with a well-designed program that provides them with a good understanding of the organizational mission; thorough training for managers and volunteers alike; continual information, briefings, and supervision; opportunities for personal growth and satisfaction; and recognition and reward for work well done.<sup>4</sup>

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<sup>4</sup> For more information on SEATS' work with youth programs, see the SEATS publication: *Applying Best Practices to Youth Reproductive Health: Lessons Learned from SEATS' Experience*, by Nancy Newton, M.A., M.P.H., January 2000.

## *Annex V:*

### *Leveraging External Resources— The Urban Initiative*

#### **Background**

The SEATS Urban Initiative was launched in 1995. It built on the ideas and proposals that flowed out of a study of three cities—Bulawayo, Zimbabwe; Blantyre, Malawi; and Mombasa, Kenya—that SEATS I carried out in collaboration with the Centre for African Family Studies (CAFS) and local research groups.

The SEATS Urban Initiative demonstrates the various approaches that can be taken to leverage additional resources in order to sustain quality reproductive services for underserved urban populations. These approaches included using previously untapped local resources, combining resources through the development of local alliances, and financial and in-kind matches of donor contributions.

The Urban Initiative promoted the use of data-driven decision-making, advocacy, and coalition building to identify and prioritize reproductive health issues for an entire city. Its main purpose was to help municipalities implement projects and activities aimed at increasing the ability of municipal leaders to meet the growing demand for accessible, high-quality family planning and reproductive health services. By 1999, the Urban Initiative included eleven subprojects undertaken by SEATS partners in Guinea (Conakry, Labe, and Kindia), Mozambique (Beira), Senegal (Louga and mayoral districts of Dakar), Zambia (Lusaka), and Zimbabwe (Bulawayo, Chitungwiza, and Gweru).

Among the flexible and effective approaches developed under the Urban Initiative for obtaining improvements in access, quality, and sustainability were the Best Practices Model and the Quick Study Model.

**The Best Practices Model** was implemented in five stages: (1) identification of urban stakeholders consisting of potential partners in the public, private, and nongovernmental sectors; (2) analysis of reproductive health data and a needs assessment by the key partners in order to identify potential best practices to adapt in a city; (3) joint planning involving SEATS, its urban partners, and other donors to determine subproject objectives and best practices to be applied; (4) implementation of the subproject; and (5) monitoring and evaluation of progress toward making high-quality, sustainable reproductive health services accessible to a growing proportion of the city's population. The Best

Practices Model was featured in the subprojects implemented by the municipal health departments of Lusaka, Zambia; Bulawayo, Chitungwiza, and Gweru, Zimbabwe; and Beira, Mozambique.

**The Quick Study Model** aimed to give elected mayors the knowledge and tools to understand the reproductive health situation in their cities and urban districts, and to design and market coherent programs to donors. The use of existing data, with only minor primary data collection to fill in critical gaps, cut in half the time needed to collect, analyze, disseminate, and use information to effect changes in programs. These cities moved from research results to subproject activities in less than a year. Collaboration among urban officials, local leaders, private-sector representatives, and donors was facilitated through the use of workshops to review research findings and to develop and review work plans for implementation. The main sites for implementation of the Quick Study Model were sections of greater Dakar and Louga, Senegal, and Conakry, Labe, and Kindia, Guinea.

### Leveraging Additional Resources—Lessons Learned

The Urban Initiative demonstrated several successful approaches to leveraging additional resources needed to sustain quality reproductive services for underserved populations. Among the main lessons learned are the following:<sup>5</sup>

- 1) Urban areas have more untapped resources available to support reproductive health programs than is commonly believed. These resources may be found within existing municipal budgets; or, they may be the result of such initiatives as new service fees and rental of clinical space.
- 2) Strengthening the links between municipal health departments and city governments can increase sustainability through joint planning and combining resources. Dialogue and regular advocacy can transform municipal authorities into stronger allies of city health departments, resulting in the allocation of additional resources to support service delivery. In Bulawayo, for example, the City Council agreed to cover some recurrent costs and equipment maintenance fees of the Family Planning Training Centre that the SEATS subproject had created, while the Health Department generated additional income through training external students on a fee-for-service basis.

<sup>5</sup> Adapted from: E. Rossi, *Meeting the Growing Demand for Quality Reproductive Health Services in Urban Africa: Partnerships with Municipal Governments* (Arlington, VA: JSI/SEATS II, December 1999), pp. 31-33.

- 3) Building advocacy and leveraging skills among urban leaders is likely to increase the long-term sustainability of urban reproductive health programs. In each Urban Initiative country, urban leaders successfully leveraged SEATS funding to obtain additional non-USAID funds and services to support municipal family planning and reproductive health activities. In Senegal and Guinea, donors such as Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), UNFPA, and the World Bank provided at least an additional US\$400,000 in funding. Similar levels of additional funding by donors and private companies were achieved in the Urban Initiative's East and Southern African countries.
- 4) Matching municipal resources with donor funds contributes to local ownership of and commitment to reproductive health activities. Municipal contributions to Urban Initiative activities were estimated to be US\$500,000 in the form of donated staff time, space and equipment, funds, and technical training. The cities most likely to complete their work plans were those making the largest monetary or in-kind contribution—a clear indication of their dedication to increasing their constituents' access to high-quality reproductive health services.

As developing countries continue to experience rapid urbanization, placing greater burdens on municipalities to provide the required basic services, and as countries increasingly decentralize their services, the need to strengthen support to cover growing populations is critical. SEATS' Urban Initiative demonstrates an approach that has proven successful at tapping into underutilized resources and mobilizing support for reproductive health services.